

PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL  
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2 AND CHILD HEALTH PLAN PROGRAM  
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21   CHAPTER 543A. QUALITY-BASED OUTCOMES AND PAYMENTS UNDER MEDICAID

22                                  AND CHILD HEALTH PLAN PROGRAM

23                                  SUBCHAPTER A. GENERAL PROVISIONS

24    Revised Law

25           Sec. 543A.0001. DEFINITIONS. In this chapter:

26                   (1) "Alternative payment system" includes:

27                                  (A) a global payment system;

28                                  (B) an episode-based bundled payment system; and

29                                  (C) a blended payment system.

30                   (2) "Blended payment system" means a system for

31   compensating a physician or other health care provider that:

32                                  (A) includes at least one feature of a global

33   payment system and an episode-based bundled payment system; and

34                                  (B) may include a system under which a portion of

1 the compensation paid to a physician or other health care provider  
2 is based on a fee-for-service payment arrangement.

3 (3) "Enrollee" means an individual enrolled in the  
4 child health plan program.

5 (4) "Episode-based bundled payment system" means a  
6 system for compensating a physician or other health care provider  
7 for providing or arranging for health care services to an enrollee  
8 or recipient that is based on a flat payment for all services  
9 provided in connection with a single episode of medical care.

10 (5) "Exclusive provider benefit plan" means a managed  
11 care plan subject to 28 T.A.C. Part 1, Chapter 3, Subchapter KK.

12 (6) "Freestanding emergency medical care facility"  
13 means a facility licensed under Chapter 254, Health and Safety  
14 Code.

15 (7) "Global payment system" means a system for  
16 compensating a physician or other health care provider for  
17 providing or arranging for a defined set of covered health care  
18 services to an enrollee or recipient for a specified period that is  
19 based on a predetermined payment per enrollee or recipient for the  
20 specified period, without regard to the quantity of services  
21 actually provided.

22 (8) "Health care provider" means a person, facility,  
23 or institution licensed, certified, registered, or chartered by  
24 this state to provide health care. The term includes an employee,  
25 independent contractor, or agent of a health care provider acting  
26 in the course and scope of the employment or contractual  
27 relationship.

28 (9) "HIV" has the meaning assigned by Section 81.101,  
29 Health and Safety Code.

30 (10) "Hospital" means an institution licensed under  
31 Chapter 241 or 577, Health and Safety Code, including a general or  
32 special hospital as defined by Section 241.003 of that code.

33 (11) "Managed care organization" means a person that  
34 is authorized or otherwise permitted by law to arrange for or

1 provide a managed care plan. The term includes a health maintenance  
2 organization and an exclusive provider organization.

3 (12) "Managed care plan" means a plan, including an  
4 exclusive provider benefit plan, under which a person undertakes to  
5 provide, arrange or pay for, or reimburse any part of the cost of  
6 health care services. The plan must include arranging for or  
7 providing health care services as distinguished from  
8 indemnification against the cost of those services on a prepaid  
9 basis through insurance or otherwise. The term does not include a  
10 plan that indemnifies a person for the cost of health care services  
11 through insurance.

12 (13) "Physician" means an individual licensed to  
13 practice medicine in this state under Subtitle B, Title 3,  
14 Occupations Code.

15 (14) "Potentially preventable admission" means an  
16 individual's admission to a hospital or long-term care facility  
17 that may have reasonably been prevented with adequate access to  
18 ambulatory care or health care coordination.

19 (15) "Potentially preventable ancillary service"  
20 means a health care service that:

21 (A) a physician or other health care provider  
22 provides or orders to supplement or support evaluating or treating  
23 a patient, including a diagnostic test, laboratory test, therapy  
24 service, or radiology service; and

25 (B) might not be reasonably necessary to provide  
26 quality health care or treatment.

27 (16) "Potentially preventable complication" means a  
28 harmful event or negative outcome with respect to an individual,  
29 including an infection or surgical complication, that:

30 (A) occurs after the individual's admission to a  
31 hospital or long-term care facility; and

32 (B) may have resulted from the care, lack of  
33 care, or treatment provided during the hospital or long-term care  
34 facility stay rather than from a natural progression of an

1 underlying disease.

2           (17) "Potentially preventable emergency room visit"  
3 means an individual's treatment in a hospital emergency room or  
4 freestanding emergency medical care facility for a condition that  
5 might not require emergency medical attention because the condition  
6 could be treated, or could have been prevented, by a physician or  
7 other health care provider in a nonemergency setting.

8           (18) "Potentially preventable event" means a:

- 9           (A) potentially preventable admission;
- 10          (B) potentially preventable ancillary service;
- 11          (C) potentially preventable complication;
- 12          (D) potentially preventable emergency room  
13 visit;
- 14          (E) potentially preventable readmission; or
- 15          (F) combination of those events.

16           (19) "Potentially preventable readmission" means an  
17 individual's return hospitalization within a period the commission  
18 specifies that may have resulted from deficiencies in the  
19 individual's care or treatment provided during a previous hospital  
20 stay or from deficiencies in post-hospital discharge follow-up. The  
21 term does not include a hospital readmission necessitated by the  
22 occurrence of unrelated events after the individual's discharge.  
23 The term includes an individual's readmission to a hospital for:

- 24          (A) the same condition or procedure for which the  
25 individual was previously admitted;
- 26          (B) an infection or other complication resulting  
27 from care previously provided;
- 28          (C) a condition or procedure indicating that a  
29 surgical intervention performed during a previous admission was  
30 unsuccessful in achieving the anticipated outcome; or
- 31          (D) another condition or procedure of a similar  
32 nature that the executive commissioner determines.

33           (20) "Quality-based payment system" means a system,  
34 including an alternative payment system, for compensating a

1 physician or other health care provider that:

2 (A) provides incentives to the physician or other  
3 health care provider to provide high-quality, cost-effective care;  
4 and

5 (B) bases some portion of the payment made to the  
6 physician or other health care provider on quality-of-care  
7 outcomes, which may include the extent to which the physician or  
8 other health care provider reduces potentially preventable events.

9 (21) "Recipient" means a Medicaid recipient. (Gov.  
10 Code, Secs. 536.001, 536.003(h); New.)

11 Source Law

12 Sec. 536.001. DEFINITIONS. In this chapter:

13 (2) "Alternative payment system"  
14 includes:

15 (A) a global payment system;  
16 (B) an episode-based bundled payment  
17 system; and

18 (C) a blended payment system.

19 (3) "Blended payment system" means a  
20 system for compensating a physician or other health  
21 care provider that includes at least one or more  
22 features of a global payment system and an  
23 episode-based bundled payment system, but that may  
24 also include a system under which a portion of the  
25 compensation paid to a physician or other health care  
26 provider is based on a fee-for-service payment  
27 arrangement.

28 (5) "Episode-based bundled payment  
29 system" means a system for compensating a physician or  
30 other health care provider for arranging for or  
31 providing health care services to child health plan  
32 program enrollees or Medicaid recipients that is based  
33 on a flat payment for all services provided in  
34 connection with a single episode of medical care.

35 (6) "Exclusive provider benefit plan"  
36 means a managed care plan subject to 28 T.A.C. Part 1,  
37 Chapter 3, Subchapter KK.

38 (7) "Freestanding emergency medical care  
39 facility" means a facility licensed under Chapter 254,  
40 Health and Safety Code.

41 (8) "Global payment system" means a system  
42 for compensating a physician or other health care  
43 provider for arranging for or providing a defined set  
44 of covered health care services to child health plan  
45 program enrollees or Medicaid recipients for a  
46 specified period that is based on a predetermined  
47 payment per enrollee or recipient, as applicable, for  
48 the specified period, without regard to the quantity  
49 of services actually provided.

50 (9) "Health care provider" means any  
51 person, partnership, professional association,  
52 corporation, facility, or institution licensed,  
53 certified, registered, or chartered by this state to  
54 provide health care. The term includes an employee,  
55 independent contractor, or agent of a health care  
56 provider acting in the course and scope of the

1 employment or contractual relationship.

2 (10) "Hospital" means a public or private  
3 institution licensed under Chapter 241 or 577, Health  
4 and Safety Code, including a general or special  
5 hospital as defined by Section 241.003, Health and  
6 Safety Code.

7 (11) "Managed care organization" means a  
8 person that is authorized or otherwise permitted by  
9 law to arrange for or provide a managed care plan. The  
10 term includes health maintenance organizations and  
11 exclusive provider organizations.

12 (12) "Managed care plan" means a plan,  
13 including an exclusive provider benefit plan, under  
14 which a person undertakes to provide, arrange for, pay  
15 for, or reimburse any part of the cost of any health  
16 care services. A part of the plan must consist of  
17 arranging for or providing health care services as  
18 distinguished from indemnification against the cost of  
19 those services on a prepaid basis through insurance or  
20 otherwise. The term does not include a plan that  
21 indemnifies a person for the cost of health care  
22 services through insurance.

23 (14) "Physician" means a person licensed  
24 to practice medicine in this state under Subtitle B,  
25 Title 3, Occupations Code.

26 (15) "Potentially preventable admission"  
27 means an admission of a person to a hospital or  
28 long-term care facility that may have reasonably been  
29 prevented with adequate access to ambulatory care or  
30 health care coordination.

31 (16) "Potentially preventable ancillary  
32 service" means a health care service provided or  
33 ordered by a physician or other health care provider to  
34 supplement or support the evaluation or treatment of a  
35 patient, including a diagnostic test, laboratory test,  
36 therapy service, or radiology service, that may not be  
37 reasonably necessary for the provision of quality  
38 health care or treatment.

39 (17) "Potentially preventable  
40 complication" means a harmful event or negative  
41 outcome with respect to a person, including an  
42 infection or surgical complication, that:

43 (A) occurs after the person's  
44 admission to a hospital or long-term care facility;  
45 and

46 (B) may have resulted from the care,  
47 lack of care, or treatment provided during the  
48 hospital or long-term care facility stay rather than  
49 from a natural progression of an underlying disease.

50 (18) "Potentially preventable event"  
51 means a potentially preventable admission, a  
52 potentially preventable ancillary service, a  
53 potentially preventable complication, a potentially  
54 preventable emergency room visit, a potentially  
55 preventable readmission, or a combination of those  
56 events.

57 (19) "Potentially preventable emergency  
58 room visit" means treatment of a person in a hospital  
59 emergency room or freestanding emergency medical care  
60 facility for a condition that may not require  
61 emergency medical attention because the condition  
62 could be, or could have been, treated or prevented by a  
63 physician or other health care provider in a  
64 nonemergency setting.

65 (20) "Potentially preventable  
66 readmission" means a return hospitalization of a  
67 person within a period specified by the commission  
68 that may have resulted from deficiencies in the care or

1 treatment provided to the person during a previous  
2 hospital stay or from deficiencies in post-hospital  
3 discharge follow-up. The term does not include a  
4 hospital readmission necessitated by the occurrence of  
5 unrelated events after the discharge. The term  
6 includes the readmission of a person to a hospital for:

7 (A) the same condition or procedure  
8 for which the person was previously admitted;

9 (B) an infection or other  
10 complication resulting from care previously provided;

11 (C) a condition or procedure that  
12 indicates that a surgical intervention performed  
13 during a previous admission was unsuccessful in  
14 achieving the anticipated outcome; or

15 (D) another condition or procedure of  
16 a similar nature, as determined by the executive  
17 commissioner.

18 (21) "Quality-based payment system" means  
19 a system for compensating a physician or other health  
20 care provider, including an alternative payment  
21 system, that provides incentives to the physician or  
22 other health care provider for providing high-quality,  
23 cost-effective care and bases some portion of the  
24 payment made to the physician or other health care  
25 provider on quality of care outcomes, which may  
26 include the extent to which the physician or other  
27 health care provider reduces potentially preventable  
28 events.

29 [Sec. 536.003]

30 (h) In this section, "HIV" has the meaning  
31 assigned by Section 81.101, Health and Safety Code.

32 Revisor's Note

33 (1) The revised law adds definitions of  
34 "enrollee" and "recipient" for drafting convenience  
35 and to avoid frequent, unnecessary repetition of the  
36 substance of the definitions.

37 (2) Section 536.001(9), Government Code, refers  
38 to "any person, partnership, professional  
39 association, corporation, facility, or institution."  
40 The revised law omits the references to "partnership,"  
41 "professional association," and "corporation" as  
42 unnecessary because the definition of "person"  
43 provided by Section 311.005(2), Government Code (Code  
44 Construction Act), which applies to the revised law,  
45 expressly includes those terms.

46 (3) Section 536.001(10), Government Code,  
47 refers to a "public or private institution." The  
48 revised law omits "public or private" because an  
49 institution is necessarily either public or private.



1 (2) in a manner that takes into account appropriate  
2 patient risk factors, including the burden of chronic illness on a  
3 patient and the severity of a patient's illness;

4 (3) that will have the greatest effect on improving  
5 quality of care and the efficient use of services, including acute  
6 care services and long-term services and supports;

7 (4) that are similar to outcome and process measures  
8 used in the private sector, as appropriate;

9 (5) that reflect effective coordination of acute care  
10 services and long-term services and supports;

11 (6) that can be tied to expenditures; and

12 (7) that reduce preventable health care utilization  
13 and costs.

14 (d) In developing the outcome and process measures, the  
15 commission must include measures that are based on potentially  
16 preventable events and advance quality improvement and innovation.  
17 The outcome measures based on potentially preventable events must:

18 (1) allow for a rate-based determination of health  
19 care provider performance compared to statewide norms; and

20 (2) be risk-adjusted to account for the severity of  
21 the illnesses of patients a provider serves.

22 (e) The commission may modify the outcome and process  
23 measures to:

24 (1) promote continuous system reform, improved  
25 quality, and reduced costs; and

26 (2) account for managed care organizations added to a  
27 service area.

28 (f) To the extent feasible, the commission shall align the  
29 outcome and process measures with measures required or recommended  
30 under reporting guidelines established by:

31 (1) the Centers for Medicare and Medicaid Services;

32 (2) the Agency for Healthcare Research and Quality; or

33 (3) another federal agency.

34 (g) The executive commissioner by rule may require

1 physicians, other health care providers, and managed care  
2 organizations participating in the child health plan program and  
3 Medicaid to report information necessary to develop the outcome and  
4 process measures to the commission in a format the executive  
5 commissioner specifies.

6 (h) If the commission increases physician and other health  
7 care provider reimbursement rates under the child health plan  
8 program or Medicaid as a result of an increase in the amounts  
9 appropriated for those programs for a state fiscal biennium as  
10 compared to the preceding state fiscal biennium, the commission  
11 shall, to the extent permitted under federal law and to the extent  
12 otherwise possible considering other relevant factors, correlate  
13 the increased reimbursement rates with the quality-based outcome  
14 and process measures. (Gov. Code, Secs. 536.003(a), (a-1), (b),  
15 (c), (d), (e), (f).)

16 Source Law

17 Sec. 536.003. DEVELOPMENT OF QUALITY-BASED  
18 OUTCOME AND PROCESS MEASURES. (a) The commission  
19 shall develop quality-based outcome and process  
20 measures that promote the provision of efficient,  
21 quality health care and that can be used in the child  
22 health plan program and Medicaid to implement  
23 quality-based payments for acute care services and  
24 long-term services and supports across all delivery  
25 models and payment systems, including fee-for-service  
26 and managed care payment systems. Subject to  
27 Subsection (a-1), the commission, in developing  
28 outcome and process measures under this section, must  
29 include measures that are based on potentially  
30 preventable events and that advance quality  
31 improvement and innovation. The commission may change  
32 measures developed:

33 (1) to promote continuous system reform,  
34 improved quality, and reduced costs; and

35 (2) to account for managed care  
36 organizations added to a service area.

37 (a-1) The outcome measures based on potentially  
38 preventable events must:

39 (1) allow for rate-based determination of  
40 health care provider performance compared to statewide  
41 norms; and

42 (2) be risk-adjusted to account for the  
43 severity of the illnesses of patients served by the  
44 provider.

45 (b) To the extent feasible, the commission shall  
46 develop outcome and process measures:

47 (1) consistently across all child health  
48 plan program and Medicaid delivery models and payment  
49 systems;

50 (2) in a manner that takes into account  
51 appropriate patient risk factors, including the burden

1 of chronic illness on a patient and the severity of a  
2 patient's illness;

3 (3) that will have the greatest effect on  
4 improving quality of care and the efficient use of  
5 services, including acute care services and long-term  
6 services and supports;

7 (4) that are similar to outcome and  
8 process measures used in the private sector, as  
9 appropriate;

10 (5) that reflect effective coordination of  
11 acute care services and long-term services and  
12 supports;

13 (6) that can be tied to expenditures; and

14 (7) that reduce preventable health care  
15 utilization and costs.

16 (c) The commission shall, to the extent  
17 feasible, align outcome and process measures developed  
18 under this section with measures required or  
19 recommended under reporting guidelines established by  
20 the federal Centers for Medicare and Medicaid  
21 Services, the Agency for Healthcare Research and  
22 Quality, or another federal agency.

23 (d) The executive commissioner by rule may  
24 require managed care organizations and physicians and  
25 other health care providers participating in the child  
26 health plan program and Medicaid to report to the  
27 commission in a format specified by the executive  
28 commissioner information necessary to develop outcome  
29 and process measures under this section.

30 (e) If the commission increases physician and  
31 other health care provider reimbursement rates under  
32 the child health plan program or Medicaid as a result  
33 of an increase in the amounts appropriated for the  
34 programs for a state fiscal biennium as compared to the  
35 preceding state fiscal biennium, the commission shall,  
36 to the extent permitted under federal law and to the  
37 extent otherwise possible considering other relevant  
38 factors, correlate the increased reimbursement rates  
39 with the quality-based outcome and process measures  
40 developed under this section.

41 (f) The commission, in coordination with the  
42 Department of State Health Services, shall develop and  
43 implement a quality-based outcome measure for the  
44 child health plan program and Medicaid to annually  
45 measure the percentage of child health plan program  
46 enrollees or Medicaid recipients with HIV infection,  
47 regardless of age, whose most recent viral load test  
48 indicates a viral load of less than 200 copies per  
49 milliliter of blood.

50 Revised Law

51 Sec. 543A.0003. USE OF QUALITY-BASED OUTCOME MEASURE FOR  
52 ENROLLEES OR RECIPIENTS WITH HIV INFECTION. (a) The commission  
53 shall include aggregate, nonidentifying data collected using the  
54 quality-based outcome measure described by Section 543A.0002(b) in  
55 the annual report required by Section 543A.0008. The commission  
56 may include the data in any other report required by this chapter.

57 (b) The commission shall determine the appropriateness of  
58 including the quality-based outcome measure described by Section

1 543A.0002(b) in the quality-based payments and payment systems  
2 developed under Sections 543A.0004 and 543A.0051. (Gov. Code, Sec.  
3 536.003(g).)

4 Source Law

5 (g) The commission shall include aggregate,  
6 nonidentifying data collected using the quality-based  
7 outcome measure described by Subsection (f) in the  
8 annual report required by Section 536.008 and may  
9 include the data in any other report required by this  
10 chapter. The commission shall determine the  
11 appropriateness of including the quality-based  
12 outcome measure described by Subsection (f) in the  
13 quality-based payments and payment systems developed  
14 under Sections 536.004 and 536.051.

15 Revised Law

16 Sec. 543A.0004. DEVELOPMENT OF QUALITY-BASED PAYMENT  
17 SYSTEMS. (a) Using the quality-based outcome and process measures  
18 developed under Section 543A.0002 and after consulting with  
19 appropriate stakeholders with an interest in the provision of acute  
20 care and long-term services and supports under the child health  
21 plan program and Medicaid, the commission shall develop and require  
22 managed care organizations to develop quality-based payment  
23 systems for compensating a physician or other health care provider  
24 participating in the child health plan program or Medicaid that:

- 25 (1) align payment incentives with high-quality,  
26 cost-effective health care;
- 27 (2) reward the use of evidence-based best practices;
- 28 (3) promote health care coordination;
- 29 (4) encourage appropriate physician and other health  
30 care provider collaboration;
- 31 (5) promote effective health care delivery models; and  
32 (6) take into account the specific needs of the  
33 enrollee and recipient populations.

34 (b) The commission shall develop the quality-based payment  
35 systems in the manner specified by this chapter. To the extent  
36 necessary to maximize the receipt of federal money or reduce  
37 administrative burdens, the commission shall coordinate the  
38 timeline for developing and implementing a payment system with the

1 implementation of other initiatives such as:

2 (1) the Medicaid Information Technology Architecture  
3 (MITA) initiative of the Center for Medicaid and State Operations;

4 (2) the ICD-10 code sets initiative; or

5 (3) the ongoing Enterprise Data Warehouse (EDW)  
6 planning process.

7 (c) In developing the quality-based payment systems, the  
8 commission shall examine and consider implementing:

9 (1) an alternative payment system;

10 (2) an existing performance-based payment system used  
11 under the Medicare program that meets the requirements of this  
12 chapter, modified as necessary to account for programmatic  
13 differences, if implementing the system would:

14 (A) reduce unnecessary administrative burdens;  
15 and

16 (B) align quality-based payment incentives for  
17 physicians and other health care providers with the Medicare  
18 program; and

19 (3) alternative payment methodologies within a system  
20 that are used in the Medicare program, modified as necessary to  
21 account for programmatic differences, and that will achieve cost  
22 savings and improve quality of care in the child health plan program  
23 and Medicaid.

24 (d) In developing the quality-based payment systems, the  
25 commission shall ensure that a system will not reward a physician,  
26 other health care provider, or managed care organization for  
27 withholding or delaying medically necessary care.

28 (e) The commission may modify a quality-based payment  
29 system to account for:

30 (1) programmatic differences between the child health  
31 plan program and Medicaid; and

32 (2) delivery systems under those programs. (Gov.  
33 Code, Sec. 536.004.)

Source Law

1  
2           Sec. 536.004. DEVELOPMENT OF QUALITY-BASED  
3 PAYMENT SYSTEMS. (a) Using quality-based outcome and  
4 process measures developed under Section 536.003 and  
5 subject to this section, the commission, after  
6 consulting with appropriate stakeholders with an  
7 interest in the provision of acute care and long-term  
8 services and supports under the child health plan  
9 program and Medicaid, shall develop quality-based  
10 payment systems, and require managed care  
11 organizations to develop quality-based payment  
12 systems, for compensating a physician or other health  
13 care provider participating in the child health plan  
14 program or Medicaid that:

15                   (1) align payment incentives with  
16 high-quality, cost-effective health care;

17                   (2) reward the use of evidence-based best  
18 practices;

19                   (3) promote the coordination of health  
20 care;

21                   (4) encourage appropriate physician and  
22 other health care provider collaboration;

23                   (5) promote effective health care delivery  
24 models; and

25                   (6) take into account the specific needs  
26 of the child health plan program enrollee and Medicaid  
27 recipient populations.

28           (b) The commission shall develop quality-based  
29 payment systems in the manner specified by this  
30 chapter. To the extent necessary, the commission shall  
31 coordinate the timeline for the development and  
32 implementation of a payment system with the  
33 implementation of other initiatives such as the  
34 Medicaid Information Technology Architecture (MITA)  
35 initiative of the Center for Medicaid and State  
36 Operations, the ICD-10 code sets initiative, or the  
37 ongoing Enterprise Data Warehouse (EDW) planning  
38 process in order to maximize the receipt of federal  
39 funds or reduce any administrative burden.

40           (c) In developing quality-based payment systems  
41 under this chapter, the commission shall examine and  
42 consider implementing:

43                   (1) an alternative payment system;

44                   (2) any existing performance-based  
45 payment system used under the Medicare program that  
46 meets the requirements of this chapter, modified as  
47 necessary to account for programmatic differences, if  
48 implementing the system would:

49                           (A) reduce unnecessary  
50 administrative burdens; and

51                           (B) align quality-based payment  
52 incentives for physicians and other health care  
53 providers with the Medicare program; and

54                   (3) alternative payment methodologies  
55 within the system that are used in the Medicare  
56 program, modified as necessary to account for  
57 programmatic differences, and that will achieve cost  
58 savings and improve quality of care in the child health  
59 plan program and Medicaid.

60           (d) In developing quality-based payment systems  
61 under this chapter, the commission shall ensure that a  
62 managed care organization or physician or other health  
63 care provider will not be rewarded by the system for  
64 withholding or delaying the provision of medically  
65 necessary care.

66           (e) The commission may modify a quality-based

1 payment system developed under this chapter to account  
2 for programmatic differences between the child health  
3 plan program and Medicaid and delivery systems under  
4 those programs.

5 Revisor's Note

6 (1) Section 536.004(a), Government Code,  
7 provides that "subject to this section," meaning  
8 Section 536.004, Government Code, the Health and Human  
9 Services Commission shall develop certain payment  
10 systems. The revised law omits the quoted language as  
11 unnecessary because the requirements of that section,  
12 which is revised as this section, apply by their own  
13 terms.

14 (2) Section 536.004(b), Government Code, refers  
15 to federal "funds." The revised law substitutes  
16 "money" for "funds" because, in context, the meaning  
17 is the same and "money" is the more commonly used term.

18 Revised Law

19 Sec. 543A.0005. PAYMENT METHODOLOGY CONVERSION. (a) To the  
20 extent possible, the commission shall convert hospital  
21 reimbursement systems under the child health plan program and  
22 Medicaid to a diagnosis-related groups (DRG) methodology that will  
23 allow the commission to more accurately classify specific patient  
24 populations and account for the severity of patient illness and  
25 mortality risk.

26 (b) Subsection (a) does not authorize the commission to  
27 direct a managed care organization to compensate a physician or  
28 other health care provider providing services under the  
29 organization's managed care plan based on a diagnosis-related  
30 groups (DRG) methodology.

31 (c) Notwithstanding Subsection (a) and to the extent  
32 possible, the commission shall convert outpatient hospital  
33 reimbursement systems under the child health plan program and  
34 Medicaid to an appropriate prospective payment system that will  
35 allow the commission to:

36 (1) more accurately classify the full range of

1 outpatient service episodes;

2 (2) more accurately account for the intensity of  
3 services provided; and

4 (3) motivate outpatient service providers to increase  
5 efficiency and effectiveness. (Gov. Code, Sec. 536.005.)

6 Source Law

7 Sec. 536.005. CONVERSION OF PAYMENT  
8 METHODOLOGY. (a) To the extent possible, the  
9 commission shall convert hospital reimbursement  
10 systems under the child health plan program and  
11 Medicaid to a diagnosis-related groups (DRG)  
12 methodology that will allow the commission to more  
13 accurately classify specific patient populations and  
14 account for severity of patient illness and mortality  
15 risk.

16 (b) Subsection (a) does not authorize the  
17 commission to direct a managed care organization to  
18 compensate physicians and other health care providers  
19 providing services under the organization's managed  
20 care plan based on a diagnosis-related groups (DRG)  
21 methodology.

22 (c) Notwithstanding Subsection (a) and to the  
23 extent possible, the commission shall convert  
24 outpatient hospital reimbursement systems under the  
25 child health plan program and Medicaid to an  
26 appropriate prospective payment system that will allow  
27 the commission to:

28 (1) more accurately classify the full  
29 range of outpatient service episodes;

30 (2) more accurately account for the  
31 intensity of services provided; and

32 (3) motivate outpatient service providers  
33 to increase efficiency and effectiveness.

34 Revised Law

35 Sec. 543A.0006. TRANSPARENCY; CONSIDERATIONS. (a) The  
36 commission shall:

37 (1) ensure transparency in developing and  
38 establishing:

39 (A) quality-based payment and reimbursement  
40 systems under Section 543A.0004 and Subchapters B, C, and D,  
41 including in developing outcome and process measures under Section  
42 543A.0002; and

43 (B) quality-based payment initiatives under  
44 Subchapter E, including developing quality-of-care and  
45 cost-efficiency benchmarks under Section 543A.0203(a) and  
46 approving efficiency performance standards under Section  
47 543A.0203(b); and

1 (2) for developing and establishing the quality-based  
2 payment and reimbursement systems and initiatives described by  
3 Subdivision (1), develop guidelines that establish procedures to  
4 provide notice and information to and receive input from managed  
5 care organizations, health care providers, including physicians  
6 and experts in the various medical specialty fields, and other  
7 stakeholders, as appropriate.

8 (b) In developing and establishing the quality-based  
9 payment and reimbursement systems and initiatives described by  
10 Subsection (a)(1), the commission shall consider that there will be  
11 a diminishing rate of improved performance over time as the  
12 performance of a physician, other health care provider, or managed  
13 care organization improves with respect to an outcome or process  
14 measure, quality-of-care and cost-efficiency benchmark, or  
15 efficiency performance standard, as applicable.

16 (c) The commission shall develop web-based capability that:

17 (1) provides health care providers and managed care  
18 organizations with data on their clinical and utilization  
19 performance, including comparisons to peer organizations and  
20 providers located in this state and in the provider's respective  
21 region; and

22 (2) supports the requirements of the electronic health  
23 information exchange system under Sections \_\_\_\_, \_\_\_\_, and \_\_\_\_  
24 [[[Sections 531.907, 531.908, and 531.909]]]. (Gov. Code, Sec.  
25 536.006.)

26 Source Law

27 Sec. 536.006. TRANSPARENCY. (a) The commission  
28 shall:

29 (1) ensure transparency in the development  
30 and establishment of:

31 (A) quality-based payment and  
32 reimbursement systems under Section 536.004 and  
33 Subchapters B, C, and D, including the development of  
34 outcome and process measures under Section 536.003;  
35 and

36 (B) quality-based payment  
37 initiatives under Subchapter E, including the  
38 development of quality of care and cost-efficiency  
39 benchmarks under Section 536.204(a) and efficiency  
40 performance standards under Section 536.204(b);

41 (2) develop guidelines establishing

1 procedures for providing notice and information to,  
2 and receiving input from, managed care organizations,  
3 health care providers, including physicians and  
4 experts in the various medical specialty fields, and  
5 other stakeholders, as appropriate, for purposes of  
6 developing and establishing the quality-based payment  
7 and reimbursement systems and initiatives described  
8 under Subdivision (1);

9 (3) in developing and establishing the  
10 quality-based payment and reimbursement systems and  
11 initiatives described under Subdivision (1), consider  
12 that as the performance of a managed care organization  
13 or physician or other health care provider improves  
14 with respect to an outcome or process measure, quality  
15 of care and cost-efficiency benchmark, or efficiency  
16 performance standard, as applicable, there will be a  
17 diminishing rate of improved performance over time;  
18 and

19 (4) develop web-based capability to  
20 provide managed care organizations and health care  
21 providers with data on their clinical and utilization  
22 performance, including comparisons to peer  
23 organizations and providers located in this state and  
24 in the provider's respective region.

25 (b) The web-based capability required by  
26 Subsection (a)(4) must support the requirements of the  
27 electronic health information exchange system under  
28 Sections 531.907 through 531.909.

29 Revised Law

30 Sec. 543A.0007. PERIODIC EVALUATION. At least once each  
31 two-year period, the commission shall evaluate the outcomes and  
32 cost-effectiveness of any quality-based payment system or other  
33 payment initiative implemented under this chapter. (Gov. Code, Sec.  
34 536.007.)

35 Source Law

36 Sec. 536.007. PERIODIC EVALUATION. (a) At  
37 least once each two-year period, the commission shall  
38 evaluate the outcomes and cost-effectiveness of any  
39 quality-based payment system or other payment  
40 initiative implemented under this chapter.

41 Revised Law

42 Sec. 543A.0008. ANNUAL REPORT. (a) The commission shall  
43 submit to the legislature and make available to the public an annual  
44 report on:

45 (1) the quality-based outcome and process measures  
46 developed under Section 543A.0002, including measures based on each  
47 potentially preventable event; and

48 (2) the progress of implementing quality-based  
49 payment systems and other payment initiatives under this chapter.

50 (b) The commission shall, as appropriate, report outcome

1 and process measures under Subsection (a)(1) by:

2 (1) geographic location, which may require reporting  
3 by county, health care service region, or another appropriately  
4 defined geographic area;

5 (2) enrollee or recipient population or eligibility  
6 group served;

7 (3) type of health care provider, such as acute care or  
8 long-term care provider;

9 (4) number of enrollees and recipients who relocated  
10 to a community-based setting from a less integrated setting;

11 (5) quality-based payment system; and

12 (6) service delivery model.

13 (c) The report may not identify a specific health care  
14 provider. (Gov. Code, Sec. 536.008.)

15 Source Law

16 Sec. 536.008. ANNUAL REPORT. (a) The  
17 commission shall submit to the legislature and make  
18 available to the public an annual report regarding:

19 (1) the quality-based outcome and process  
20 measures developed under Section 536.003, including  
21 measures based on each potentially preventable event;  
22 and

23 (2) the progress of the implementation of  
24 quality-based payment systems and other payment  
25 initiatives implemented under this chapter.

26 (b) As appropriate, the commission shall report  
27 outcome and process measures under Subsection (a)(1)  
28 by:

29 (1) geographic location, which may require  
30 reporting by county, health care service region, or  
31 other appropriately defined geographic area;

32 (2) recipient population or eligibility  
33 group served;

34 (3) type of health care provider, such as  
35 acute care or long-term care provider;

36 (4) number of recipients who relocated to  
37 a community-based setting from a less integrated  
38 setting;

39 (5) quality-based payment system; and

40 (6) service delivery model.

41 (c) The report required under this section may  
42 not identify specific health care providers.

43 Revisor's Note

44 Sections 536.008(b)(2) and (4), Government Code,  
45 refer to "recipient population" and "recipients,"  
46 respectively, to whom certain outcome and process  
47 measures relate. The revised law in Section 543A.0001

1 of this chapter adds a definition of "recipient" to  
2 mean a Medicaid recipient. That revised law also adds  
3 a definition of "enrollee" to mean an individual  
4 enrolled in the child health plan program. Because the  
5 outcome and process measures to which Section 536.008,  
6 Government Code, refers relate to both the child  
7 health plan program and Medicaid, it is clear that the  
8 term "recipient" as used in Sections 536.008(b)(2) and  
9 (4) is intended to mean both Medicaid recipients and  
10 child health plan program enrollees, rather than the  
11 more restrictive definition of "recipient" as added in  
12 the revised law. Therefore, the revised law  
13 substitutes "enrollee or recipient population" and  
14 "enrollees and recipients" for the references to  
15 "recipient population" and "recipients,"  
16 respectively.

17 SUBCHAPTER B. QUALITY-BASED PAYMENTS RELATING TO MANAGED CARE

18 ORGANIZATIONS

19 Revised Law

20 Sec. 543A.0051. QUALITY-BASED PREMIUM PAYMENTS;  
21 PERFORMANCE REPORTING. (a) Subject to Section 1903(m)(2)(A),  
22 Social Security Act (42 U.S.C. Section 1396b(m)(2)(A)), and other  
23 federal law, the commission shall base a percentage of the premiums  
24 paid to a managed care organization participating in the child  
25 health plan program or Medicaid on the organization's performance  
26 with respect to outcome and process measures developed under  
27 Section 543A.0002 that address potentially preventable events. The  
28 percentage may increase each year.

29 (b) The commission shall make available information  
30 relating to a managed care organization's performance with respect  
31 to outcome and process measures under this subchapter to an  
32 enrollee or recipient before the enrollee or recipient chooses a  
33 managed care plan. (Gov. Code, Sec. 536.051.)

1 Source Law

2 Sec. 536.051. DEVELOPMENT OF QUALITY-BASED  
3 PREMIUM PAYMENTS; PERFORMANCE REPORTING. (a) Subject  
4 to Section 1903(m)(2)(A), Social Security Act (42  
5 U.S.C. Section 1396b(m)(2)(A)), and other applicable  
6 federal law, the commission shall base a percentage of  
7 the premiums paid to a managed care organization  
8 participating in the child health plan program or  
9 Medicaid on the organization's performance with  
10 respect to outcome and process measures developed  
11 under Section 536.003 that address potentially  
12 preventable events. The percentage of the premiums  
13 paid may increase each year.

14 (b) The commission shall make available  
15 information relating to the performance of a managed  
16 care organization with respect to outcome and process  
17 measures under this subchapter to child health plan  
18 program enrollees and Medicaid recipients before those  
19 enrollees and recipients choose their managed care  
20 plans.

21 Revised Law

22 Sec. 543A.0052. FINANCIAL INCENTIVES AND CONTRACT AWARD  
23 PREFERENCES. (a) The commission may allow a managed care  
24 organization participating in the child health plan program or  
25 Medicaid increased flexibility to implement quality initiatives in  
26 a managed care plan offered by the organization, including  
27 flexibility with respect to financial arrangements, to:

28 (1) achieve high-quality, cost-effective health care;

29 (2) increase the use of high-quality, cost-effective  
30 delivery models;

31 (3) reduce the incidence of unnecessary  
32 institutionalization and potentially preventable events; and

33 (4) in collaboration with physicians and other health  
34 care providers, increase the use of alternative payment systems,  
35 including shared savings models.

36 (b) The commission shall develop quality-of-care and  
37 cost-efficiency benchmarks, including benchmarks based on a  
38 managed care organization's performance with respect to:

39 (1) reducing potentially preventable events; and

40 (2) containing the growth rate of health care costs.

41 (c) The commission may include in a contract between a  
42 managed care organization and the commission financial incentives  
43 that are based on the organization's successful implementation of

1 quality initiatives under Subsection (a) or success in achieving  
2 quality-of-care and cost-efficiency benchmarks under Subsection  
3 (b). The commission may implement the financial incentives only if  
4 implementing the incentives would be cost-effective.

5 (d) In awarding contracts to managed care organizations  
6 under the child health plan program and Medicaid, the commission  
7 shall, in addition to considerations under Section \_\_\_\_ [[[Section  
8 533.003]]] of this code and Section 62.155, Health and Safety Code,  
9 give preference to an organization that offers a managed care plan  
10 that:

11 (1) successfully implements quality initiatives under  
12 Subsection (a) as the commission determines based on data or other  
13 evidence the organization provides; or

14 (2) meets quality-of-care and cost-efficiency  
15 benchmarks under Subsection (b). (Gov. Code, Sec. 536.052.)

16 Source Law

17 Sec. 536.052. PAYMENT AND CONTRACT AWARD  
18 INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) The  
19 commission may allow a managed care organization  
20 participating in the child health plan program or  
21 Medicaid increased flexibility to implement quality  
22 initiatives in a managed care plan offered by the  
23 organization, including flexibility with respect to  
24 financial arrangements, in order to:

25 (1) achieve high-quality, cost-effective  
26 health care;

27 (2) increase the use of high-quality,  
28 cost-effective delivery models;

29 (3) reduce the incidence of unnecessary  
30 institutionalization and potentially preventable  
31 events; and

32 (4) increase the use of alternative  
33 payment systems, including shared savings models, in  
34 collaboration with physicians and other health care  
35 providers.

36 (b) The commission shall develop quality of care  
37 and cost-efficiency benchmarks, including benchmarks  
38 based on a managed care organization's performance  
39 with respect to reducing potentially preventable  
40 events and containing the growth rate of health care  
41 costs.

42 (c) The commission may include in a contract  
43 between a managed care organization and the commission  
44 financial incentives that are based on the  
45 organization's successful implementation of quality  
46 initiatives under Subsection (a) or success in  
47 achieving quality of care and cost-efficiency  
48 benchmarks under Subsection (b).

49 (d) In awarding contracts to managed care  
50 organizations under the child health plan program and  
51 Medicaid, the commission shall, in addition to

1 considerations under Section 533.003 of this code and  
2 Section 62.155, Health and Safety Code, give  
3 preference to an organization that offers a managed  
4 care plan that successfully implements quality  
5 initiatives under Subsection (a) as determined by the  
6 commission based on data or other evidence provided by  
7 the organization or meets quality of care and  
8 cost-efficiency benchmarks under Subsection (b).

9 (e) The commission may implement financial  
10 incentives under this section only if implementing the  
11 incentives would be cost-effective.

12 SUBCHAPTER C. QUALITY-BASED HEALTH HOME PAYMENT SYSTEMS

13 Revised Law

14 Sec. 543A.0101. DEFINITION. In this subchapter, "health  
15 home" means a primary care provider practice or, if appropriate, a  
16 specialty care provider practice, incorporating several features,  
17 including comprehensive care coordination, family-centered care,  
18 and data management, that are focused on improving outcome-based  
19 quality of care and increasing patient and provider satisfaction  
20 under the child health plan program and Medicaid. (Gov. Code, Sec.  
21 536.101(1).)

22 Source Law

23 Sec. 536.101. DEFINITIONS. In this subchapter:

24 (1) "Health home" means a primary care  
25 provider practice or, if appropriate, a specialty care  
26 provider practice, incorporating several features,  
27 including comprehensive care coordination,  
28 family-centered care, and data management, that are  
29 focused on improving outcome-based quality of care and  
30 increasing patient and provider satisfaction under the  
31 child health plan program and Medicaid.

32 Revisor's Note

33 Section 536.101(2), Government Code, defines  
34 "participating enrollee" for purposes of Subchapter C,  
35 Chapter 536, Government Code, which is revised as this  
36 subchapter. For clarity, the revised law incorporates  
37 the substance of the definition into the revised law in  
38 each place the term appears and omits the definition.

39 The omitted law reads:

40 (2) "Participating enrollee"  
41 means a child health plan program enrollee  
42 or Medicaid recipient who has a health home.

43 Revised Law

44 Sec. 543A.0102. QUALITY-BASED HEALTH HOME PAYMENTS. (a)

1 The commission may develop and implement quality-based payment  
2 systems for health homes designed to improve quality of care and  
3 reduce the provision of unnecessary medical services. A  
4 quality-based payment system must:

5 (1) base payments made to an enrollee's or recipient's  
6 health home on quality and efficiency measures that may include  
7 measurable wellness and prevention criteria and the use of  
8 evidence-based best practices, sharing a portion of any realized  
9 cost savings the health home achieves, and ensuring quality of care  
10 outcomes, including a reduction in potentially preventable events;  
11 and

12 (2) allow for the examination of measurable wellness  
13 and prevention criteria, use of evidence-based best practices, and  
14 quality-of-care outcomes based on the type of primary or specialty  
15 care provider practice.

16 (b) The commission may develop a quality-based payment  
17 system for health homes only if implementing the system would be  
18 feasible and cost-effective. (Gov. Code, Sec. 536.102.)

19 Source Law

20 Sec. 536.102. QUALITY-BASED HEALTH HOME  
21 PAYMENTS. (a) Subject to this subchapter, the  
22 commission may develop and implement quality-based  
23 payment systems for health homes designed to improve  
24 quality of care and reduce the provision of  
25 unnecessary medical services. A quality-based payment  
26 system developed under this section must:

27 (1) base payments made to a participating  
28 enrollee's health home on quality and efficiency  
29 measures that may include measurable wellness and  
30 prevention criteria and use of evidence-based best  
31 practices, sharing a portion of any realized cost  
32 savings achieved by the health home, and ensuring  
33 quality of care outcomes, including a reduction in  
34 potentially preventable events; and

35 (2) allow for the examination of  
36 measurable wellness and prevention criteria, use of  
37 evidence-based best practices, and quality of care  
38 outcomes based on the type of primary or specialty care  
39 provider practice.

40 (b) The commission may develop a quality-based  
41 payment system for health homes under this subchapter  
42 only if implementing the system would be feasible and  
43 cost-effective.

44 Revisor's Note

45 Section 536.102(a), Government Code, provides

1 that "[s]ubject to this subchapter," meaning  
2 Subchapter C, Chapter 536, Government Code, the Health  
3 and Human Services Commission may develop and  
4 implement certain payment systems. The revised law  
5 omits the quoted language for the reason stated in  
6 Revisor's Note (1) to Section 543A.0004 of this  
7 chapter.

#### 8 Revised Law

9 Sec. 543A.0103. HEALTH HOME ELIGIBILITY. To be eligible to  
10 receive reimbursement under a quality-based payment system under  
11 this subchapter, a health home must:

12 (1) directly or indirectly provide enrollees or  
13 recipients who have a health home with access to health care  
14 services outside of regular business hours;

15 (2) educate those enrollees and recipients about the  
16 availability of health care services outside of regular business  
17 hours; and

18 (3) provide evidence satisfactory to the commission  
19 that the health home meets the requirement of Subdivision (1).  
20 (Gov. Code, Sec. 536.103.)

#### 21 Source Law

22 Sec. 536.103. PROVIDER ELIGIBILITY. To be  
23 eligible to receive reimbursement under a  
24 quality-based payment system under this subchapter, a  
25 health home provider must:

26 (1) provide participating enrollees,  
27 directly or indirectly, with access to health care  
28 services outside of regular business hours;

29 (2) educate participating enrollees about  
30 the availability of health care services outside of  
31 regular business hours; and

32 (3) provide evidence satisfactory to the  
33 commission that the provider meets the requirement of  
34 Subdivision (1).

#### 35 Revisor's Note

36 Section 536.103, Government Code, refers to a  
37 "health home provider." The revised law substitutes  
38 "health home" for "health home provider" because  
39 "health home" is the defined term under Section  
40 536.101(1), Government Code, revised in this

1 subchapter as Section 543A.0101, and a health home is  
2 defined as a type of provider.

3 SUBCHAPTER D. QUALITY-BASED HOSPITAL REIMBURSEMENT SYSTEM

4 Revised Law

5 Sec. 543A.0151. COLLECTING CERTAIN INFORMATION; REPORTS TO  
6 CERTAIN HOSPITALS. (a) The executive commissioner shall adopt  
7 rules for identifying:

8 (1) potentially preventable admissions and  
9 readmissions of enrollees and recipients, including preventable  
10 admissions to long-term care facilities;

11 (2) potentially preventable ancillary services  
12 provided to or ordered for enrollees and recipients;

13 (3) potentially preventable emergency room visits by  
14 enrollees and recipients; and

15 (4) potentially preventable complications experienced  
16 by enrollees and recipients.

17 (b) The commission shall collect data from hospitals on  
18 present-on-admission indicators for purposes of this section.

19 (c) The commission shall establish a program to provide to  
20 each hospital in this state that participates in the child health  
21 plan program or Medicaid a report regarding the hospital's  
22 performance with respect to each potentially preventable event  
23 described by Subsection (a). To the extent possible, the report  
24 should include all potentially preventable events across all child  
25 health plan program and Medicaid payment systems. A hospital shall  
26 distribute the information in the report to physicians and other  
27 health care providers providing services at the hospital.

28 (d) Except as provided by Subsection (e), a report provided  
29 to a hospital under Subsection (c) is confidential and not subject  
30 to Chapter 552.

31 (e) The commission may release information in a report  
32 described by Subsection (c):

33 (1) not earlier than one year after the date the report  
34 is provided to the hospital; and

1 (2) only after deleting any data that relates to a  
2 hospital's performance with respect to a particular  
3 diagnosis-related group or an individual patient. (Gov. Code, Sec.  
4 536.151.)

5 Source Law

6 Sec. 536.151. COLLECTION AND REPORTING OF  
7 CERTAIN INFORMATION. (a) The executive commissioner  
8 shall adopt rules for identifying:

9 (1) potentially preventable admissions  
10 and readmissions of child health plan program  
11 enrollees and Medicaid recipients, including  
12 preventable admissions to long-term care facilities;

13 (2) potentially preventable ancillary  
14 services provided to or ordered for child health plan  
15 program enrollees and Medicaid recipients;

16 (3) potentially preventable emergency  
17 room visits by child health plan program enrollees and  
18 Medicaid recipients; and

19 (4) potentially preventable complications  
20 experienced by child health plan program enrollees and  
21 Medicaid recipients.

22 (a-1) The commission shall collect data from  
23 hospitals on present-on-admission indicators for  
24 purposes of this section.

25 (b) The commission shall establish a program to  
26 provide a confidential report to each hospital in this  
27 state that participates in the child health plan  
28 program or Medicaid regarding the hospital's  
29 performance with respect to each potentially  
30 preventable event described under Subsection (a). To  
31 the extent possible, a report provided under this  
32 section should include all potentially preventable  
33 events across all child health plan program and  
34 Medicaid payment systems. A hospital shall distribute  
35 the information contained in the report to physicians  
36 and other health care providers providing services at  
37 the hospital.

38 (c) Except as provided by Subsection (d), a  
39 report provided to a hospital under this section is  
40 confidential and is not subject to Chapter 552.

41 (d) The commission may release the information  
42 in the report described by Subsection (b):

43 (1) not earlier than one year after the  
44 date the report is submitted to the hospital; and

45 (2) only after deleting any data that  
46 relates to a hospital's performance with respect to  
47 particular diagnosis-related groups or individual  
48 patients.

49 Revised Law

50 Sec. 543A.0152. REIMBURSEMENT ADJUSTMENTS. (a) The  
51 commission shall use the data collected under Section 543A.0151 and  
52 the diagnosis-related groups (DRG) methodology implemented under  
53 Section 543A.0005, if applicable, to adjust, to the extent  
54 feasible, child health plan program and Medicaid reimbursements to  
55 hospitals, including payments made under the disproportionate

1 share hospitals and upper payment limit supplemental payment  
2 programs. The commission shall base an adjustment for a hospital on  
3 the hospital's performance with respect to exceeding or failing to  
4 achieve outcome and process measures developed under Section  
5 543A.0002 that address the rates of potentially preventable  
6 readmissions and potentially preventable complications.

7 (b) The commission must provide the report required by  
8 Section 543A.0151(c) to a hospital at least one year before  
9 adjusting child health plan program and Medicaid reimbursements to  
10 the hospital under this section. (Gov. Code, Sec. 536.152.)

11 Source Law

12 Sec. 536.152. REIMBURSEMENT ADJUSTMENTS. (a)  
13 Subject to Subsection (b), using the data collected  
14 under Section 536.151 and the diagnosis-related groups  
15 (DRG) methodology implemented under Section 536.005,  
16 if applicable, the commission shall to the extent  
17 feasible adjust child health plan and Medicaid  
18 reimbursements to hospitals, including payments made  
19 under the disproportionate share hospitals and upper  
20 payment limit supplemental payment programs, based on  
21 the hospital's performance with respect to exceeding,  
22 or failing to achieve, outcome and process measures  
23 developed under Section 536.003 that address the rates  
24 of potentially preventable readmissions and  
25 potentially preventable complications.

26 (b) The commission must provide the report  
27 required under Section 536.151(b) to a hospital at  
28 least one year before the commission adjusts child  
29 health plan and Medicaid reimbursements to the  
30 hospital under this section.

31 Revisor's Note

32 Section 536.152(a), Government Code, provides  
33 that "[s]ubject to Subsection (b)," meaning Section  
34 536.152(b), Government Code, the Health and Human  
35 Services Commission shall adjust certain hospital  
36 reimbursements. The revised law omits the quoted  
37 language for the reason stated in Revisor's Note (1) to  
38 Section 543A.0004 of this chapter.

39 SUBCHAPTER E. QUALITY-BASED PAYMENT INITIATIVES

40 Revised Law

41 Sec. 543A.0201. PAYMENT INITIATIVES; DETERMINATION OF  
42 BENEFIT TO STATE. (a) The commission shall establish payment  
43 initiatives to test the effectiveness of quality-based payment

1 systems, alternative payment methodologies, and high-quality,  
2 cost-effective health care delivery models that provide incentives  
3 to physicians and other health care providers to develop health  
4 care interventions for enrollees or recipients that will:

5 (1) improve the quality of health care provided to the  
6 enrollees or recipients;

7 (2) reduce potentially preventable events;

8 (3) promote prevention and wellness;

9 (4) increase the use of evidence-based best practices;

10 (5) increase appropriate physician and other health  
11 care provider collaboration;

12 (6) contain costs; and

13 (7) improve integration of acute care services and  
14 long-term services and supports, including discharge planning from  
15 acute care services to community-based long-term services and  
16 supports.

17 (b) The commission shall:

18 (1) establish a process through which a physician,  
19 other health care provider, or managed care organization may submit  
20 a proposal for a payment initiative; and

21 (2) determine whether implementing one or more  
22 proposed payment initiatives is feasible and cost-effective.

23 (c) If the commission determines that implementing one or  
24 more payment initiatives is feasible and cost-effective for this  
25 state, the commission shall establish one or more payment  
26 initiatives as provided by this subchapter. (Gov. Code, Secs.  
27 536.202, 536.203(a).)

28 Source Law

29 Sec. 536.202. PAYMENT INITIATIVES;  
30 DETERMINATION OF BENEFIT TO STATE. (a) The commission  
31 shall establish payment initiatives to test the  
32 effectiveness of quality-based payment systems,  
33 alternative payment methodologies, and high-quality,  
34 cost-effective health care delivery models that  
35 provide incentives to physicians and other health care  
36 providers to develop health care interventions for  
37 child health plan program enrollees or Medicaid  
38 recipients, or both, that will:

39 (1) improve the quality of health care

1 provided to the enrollees or recipients;  
2 (2) reduce potentially preventable  
3 events;  
4 (3) promote prevention and wellness;  
5 (4) increase the use of evidence-based  
6 best practices;  
7 (5) increase appropriate physician and  
8 other health care provider collaboration;  
9 (6) contain costs; and  
10 (7) improve integration of acute care  
11 services and long-term services and supports,  
12 including discharge planning from acute care services  
13 to community-based long-term services and supports.

14 (b) The commission shall:

15 (1) establish a process by which managed  
16 care organizations and physicians and other health  
17 care providers may submit proposals for payment  
18 initiatives described by Subsection (a); and

19 (2) determine whether it is feasible and  
20 cost-effective to implement one or more of the  
21 proposed payment initiatives.

22 Sec. 536.203. PURPOSE AND IMPLEMENTATION OF  
23 PAYMENT INITIATIVES. (a) If the commission  
24 determines under Section 536.202 that implementation  
25 of one or more payment initiatives is feasible and  
26 cost-effective for this state, the commission shall  
27 establish one or more payment initiatives as provided  
28 by this subchapter.

#### 29 Revisor's Note

30 Section 536.202(a), Government Code, provides  
31 that the Health and Human Services Commission "shall"  
32 establish payment initiatives to test certain payment  
33 systems, payment methodologies, and health care  
34 delivery models. In contrast, Section 536.203(a),  
35 Government Code, requires the commission to establish  
36 one or more of those payment initiatives if the  
37 commission determines that implementing the  
38 initiatives is feasible and cost-effective. The  
39 requirements imposed on the commission by the two  
40 provisions appear to conflict, and the revised law  
41 preserves the ambiguity.

#### 42 Revised Law

43 Sec. 543A.0202. PAYMENT INITIATIVE ADMINISTRATION. (a)  
44 The commission shall administer any payment initiative the  
45 commission establishes under this subchapter. The executive  
46 commissioner may adopt rules, plans, and procedures and enter into  
47 contracts and other agreements as the executive commissioner  
48 considers appropriate and necessary to administer this subchapter.

1 (b) The commission may limit a payment initiative to:

2 (1) one or more regions in this state;

3 (2) one or more organized networks of physicians and  
4 other health care providers; or

5 (3) specified types of services provided under the  
6 child health plan program or Medicaid, or specified types of  
7 enrollees or recipients.

8 (c) An implemented payment initiative must be operated for  
9 at least one calendar year. (Gov. Code, Secs. 536.203(b), (c),  
10 (d).)

11 Source Law

12 (b) The commission shall administer any payment  
13 initiative established under this subchapter. The  
14 executive commissioner may adopt rules, plans, and  
15 procedures and enter into contracts and other  
16 agreements as the executive commissioner considers  
17 appropriate and necessary to administer this  
18 subchapter.

19 (c) The commission may limit a payment  
20 initiative to:

21 (1) one or more regions in this state;

22 (2) one or more organized networks of  
23 physicians and other health care providers; or

24 (3) specified types of services provided  
25 under the child health plan program or Medicaid, or  
26 specified types of enrollees or recipients under those  
27 programs.

28 (d) A payment initiative implemented under this  
29 subchapter must be operated for at least one calendar  
30 year.

31 Revised Law

32 Sec. 543A.0203. QUALITY-OF-CARE AND COST-EFFICIENCY  
33 BENCHMARKS AND GOALS; EFFICIENCY PERFORMANCE STANDARDS. (a) The  
34 executive commissioner shall develop quality-of-care and  
35 cost-efficiency benchmarks and measurable goals that a payment  
36 initiative must meet to ensure high-quality and cost-effective  
37 health care services and healthy outcomes.

38 (b) In addition to the benchmarks and goals described by  
39 Subsection (a), the executive commissioner may approve efficiency  
40 performance standards that may include the sharing of realized cost  
41 savings with physicians and other health care providers who provide  
42 health care services that exceed the standards. The standards may  
43 not create a financial incentive for or involve making a payment to

1 a physician or other health care provider that directly or  
2 indirectly induces limiting medically necessary services. (Gov.  
3 Code, Sec. 536.204.)

4 Source Law

5 Sec. 536.204. STANDARDS; PROTOCOLS. (a) The  
6 executive commissioner shall develop quality of care  
7 and cost-efficiency benchmarks and measurable goals  
8 that a payment initiative must meet to ensure  
9 high-quality and cost-effective health care services  
10 and healthy outcomes.

11 (b) In addition to the benchmarks and goals  
12 under Subsection (a), the executive commissioner may  
13 approve efficiency performance standards that may  
14 include the sharing of realized cost savings with  
15 physicians and other health care providers who provide  
16 health care services that exceed the efficiency  
17 performance standards. The efficiency performance  
18 standards may not create any financial incentive for  
19 or involve making a payment to a physician or other  
20 health care provider that directly or indirectly  
21 induces the limitation of medically necessary  
22 services.

23 Revised Law

24 Sec. 543A.0204. PAYMENT RATES UNDER PAYMENT INITIATIVES.  
25 The executive commissioner may contract with appropriate entities,  
26 including qualified actuaries, to assist in determining  
27 appropriate payment rates for an implemented payment initiative.  
28 (Gov. Code, Sec. 536.205.)

29 Source Law

30 Sec. 536.205. PAYMENT RATES UNDER PAYMENT  
31 INITIATIVES. The executive commissioner may contract  
32 with appropriate entities, including qualified  
33 actuaries, to assist in determining appropriate  
34 payment rates for a payment initiative implemented  
35 under this subchapter.

36 Revisor's Note  
37 (End of Subchapter)

38 Section 536.201, Government Code, defines  
39 "payment initiative" for purposes of Subchapter E,  
40 Chapter 536, Government Code, as "a quality-based  
41 payment initiative established under" that  
42 subchapter.

43 The revised law omits the definition in part  
44 because it is misleading and therefore does not add to  
45 the clear meaning of the law. Throughout the

1 subchapter, the term is not consistently used in the  
2 manner in which it is defined. For example, Section  
3 536.202(b)(1), Government Code, which is revised in  
4 this subchapter as Section 543A.0201(b)(1),  
5 authorizes certain persons to submit "proposals for  
6 payment initiatives," and Section 536.202(b)(2),  
7 Government Code, which is revised in this subchapter  
8 as Section 543A.0201(b)(2), refers to "proposed  
9 payment initiatives." A proposed payment initiative is  
10 not an initiative that necessarily has been or will be  
11 "established" as specified by the definition in  
12 Section 536.201.

13 The revised law also omits the definition as  
14 unnecessary. In each occurrence of the term, the  
15 meaning is clear from the context in which it is used.  
16 The omitted law reads:

17 Sec. 536.201. DEFINITION. In this  
18 subchapter, "payment initiative" means a  
19 quality-based payment initiative  
20 established under this subchapter.

21 SUBCHAPTER F. QUALITY-BASED LONG-TERM SERVICES AND SUPPORTS

22 PAYMENT SYSTEMS

23 Revised Law

24 Sec. 543A.0251. QUALITY-BASED PAYMENT SYSTEMS FOR  
25 LONG-TERM SERVICES AND SUPPORTS. (a) The commission, after  
26 consulting with appropriate stakeholders representing nursing  
27 facility providers with an interest in providing long-term services  
28 and supports, may develop and implement quality-based payment  
29 systems for Medicaid long-term services and supports providers  
30 designed to improve quality of care and reduce the provision of  
31 unnecessary services. A quality-based payment system must base  
32 payments made to providers on quality and efficiency measures that  
33 may include measurable wellness and prevention criteria and the use  
34 of evidence-based best practices, sharing a portion of any realized  
35 cost savings the provider achieves, and ensuring quality of care

1 outcomes, including a reduction in potentially preventable events.

2 (b) The commission may develop a quality-based payment  
3 system for Medicaid long-term services and supports providers only  
4 if implementing the system would be feasible and cost-effective.  
5 (Gov. Code, Sec. 536.251.)

6 Source Law

7 Sec. 536.251. QUALITY-BASED LONG-TERM SERVICES  
8 AND SUPPORTS PAYMENTS. (a) Subject to this subchapter,  
9 the commission, after consulting with appropriate  
10 stakeholders representing nursing facility providers  
11 with an interest in the provision of long-term  
12 services and supports, may develop and implement  
13 quality-based payment systems for Medicaid long-term  
14 services and supports providers designed to improve  
15 quality of care and reduce the provision of  
16 unnecessary services. A quality-based payment system  
17 developed under this section must base payments to  
18 providers on quality and efficiency measures that may  
19 include measurable wellness and prevention criteria  
20 and use of evidence-based best practices, sharing a  
21 portion of any realized cost savings achieved by the  
22 provider, and ensuring quality of care outcomes,  
23 including a reduction in potentially preventable  
24 events.

25 (b) The commission may develop a quality-based  
26 payment system for Medicaid long-term services and  
27 supports providers under this subchapter only if  
28 implementing the system would be feasible and  
29 cost-effective.

30 Revisor's Note

31 Section 536.251(a), Government Code, provides  
32 that "[s]ubject to this subchapter," meaning  
33 Subchapter F, Chapter 536, Government Code, the Health  
34 and Human Services Commission may develop and  
35 implement certain payment systems. The revised law  
36 omits the quoted language for the reason stated in  
37 Revisor's Note (1) to Section 543A.0004 of this  
38 chapter.

39 Revised Law

40 Sec. 543A.0252. DATA SET EVALUATION. To ensure that the  
41 commission is using the best data to inform developing and  
42 implementing quality-based payment systems under Section  
43 543A.0251, the commission shall evaluate the reliability,  
44 validity, and functionality of post-acute and long-term services  
45 and supports data sets. The commission's evaluation should assess:

1 (1) to what degree data sets on which the commission  
2 relies meet a standard:

3 (A) for integrating care;

4 (B) for developing coordinated care plans; and

5 (C) that would allow for the meaningful  
6 development of risk adjustment techniques;

7 (2) whether the data sets will provide value for  
8 outcome or performance measures and cost containment; and

9 (3) how classification systems and data sets used for  
10 Medicaid long-term services and supports providers can be  
11 standardized and, where possible, simplified. (Gov. Code, Sec.  
12 536.252.)

13 Source Law

14 Sec. 536.252. EVALUATION OF DATA SETS. To  
15 ensure that the commission is using the best data to  
16 inform the development and implementation of  
17 quality-based payment systems under Section 536.251,  
18 the commission shall evaluate the reliability,  
19 validity, and functionality of post-acute and  
20 long-term services and supports data sets. The  
21 commission's evaluation under this section should  
22 assess:

23 (1) to what degree data sets relied on by  
24 the commission meet a standard:

25 (A) for integrating care;

26 (B) for developing coordinated care  
27 plans; and

28 (C) that would allow for the  
29 meaningful development of risk adjustment techniques;

30 (2) whether the data sets will provide  
31 value for outcome or performance measures and cost  
32 containment; and

33 (3) how classification systems and data  
34 sets used for Medicaid long-term services and supports  
35 providers can be standardized and, where possible,  
36 simplified.

37 Revised Law

38 Sec. 543A.0253. COLLECTING CERTAIN INFORMATION; REPORTS TO  
39 CERTAIN PROVIDERS. (a) The executive commissioner shall adopt  
40 rules for identifying the incidence of potentially preventable  
41 admissions, potentially preventable readmissions, and potentially  
42 preventable emergency room visits by Medicaid long-term services  
43 and supports recipients.

44 (b) The commission shall establish a program to provide to  
45 each Medicaid long-term services and supports provider in this

1 state a report regarding the provider's performance with respect to  
2 potentially preventable admissions, potentially preventable  
3 readmissions, and potentially preventable emergency room visits.  
4 To the extent possible, the report should include applicable  
5 potentially preventable events information across all Medicaid  
6 payment systems.

7 (c) Except as provided by Subsection (d), a report provided  
8 to a provider under Subsection (b) is confidential and not subject  
9 to Chapter 552.

10 (d) The commission may release information in a report  
11 described by Subsection (b):

12 (1) not earlier than one year after the date the report  
13 is provided to the provider; and

14 (2) only after deleting any data that relates to a  
15 provider's performance with respect to a particular resource  
16 utilization group or an individual recipient. (Gov. Code, Sec.  
17 536.253.)

18 Source Law

19 Sec. 536.253. COLLECTION AND REPORTING OF  
20 CERTAIN INFORMATION. (a) The executive commissioner  
21 shall adopt rules for identifying the incidence of  
22 potentially preventable admissions, potentially  
23 preventable readmissions, and potentially preventable  
24 emergency room visits by Medicaid long-term services  
25 and supports recipients.

26 (b) The commission shall establish a program to  
27 provide a report to each Medicaid long-term services  
28 and supports provider in this state regarding the  
29 provider's performance with respect to potentially  
30 preventable admissions, potentially preventable  
31 readmissions, and potentially preventable emergency  
32 room visits. To the extent possible, a report provided  
33 under this section should include applicable  
34 potentially preventable events information across all  
35 Medicaid payment systems.

36 (c) Subject to Subsection (d), a report provided  
37 to a provider under this section is confidential and is  
38 not subject to Chapter 552.

39 (d) The commission may release the information  
40 in the report described by Subsection (b):

41 (1) not earlier than one year after the  
42 date the report is submitted to the provider; and

43 (2) only after deleting any data that  
44 relates to a provider's performance with respect to  
45 particular resource utilization groups or individual  
46 recipients.